LGBT Health

A National Survey of Faculty Knowledge, Experience, and Readiness for Teaching Lesbian, Gay, Bisexual and Transgender Health in Baccalaureate Nursing Programs

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Abstract

AIM This article assesses the knowledge of faculty in baccalaureate nursing programs and their readiness to teach about lesbian, gay, bisexual, and transgender (LGBT) health.
BACKGROUND Although health disparities affecting the LGBT population are increasingly acknowledged in the literature, a dearth of information exists on how LGBT health is integrated in nursing programs.
METHOD A survey was sent to a nonprobability purposive sample of nursing school administrative leaders (N = 739); they were asked to share the link with their faculty. More than 1,000 faculty completed the survey.
RESULTS The knowledge, experience, and readiness for teaching LGBT health among baccalaureate faculty are limited. LGBT faculty reported greater awareness, knowledge, and readiness compared with heterosexual faculty. The estimated median time devoted to teaching LGBT health was 2.12 hours.
CONCLUSION Findings will help inform the design of faculty development programs and guide them in aligning the curricula with current LGBT health priorities.

Nursing education has a mandate to educate graduates with competencies in patient-centered care, including culturally competent care (Institute of Medicine [IOM], 2003). Patient-centered care is of vital importance in the care of persons who identify as members of the lesbian, gay, bisexual, and transgender (LGBT) population because of the long history of sexual stigma and systematic discrimination this collective group has experienced. Education is likely to be foundational in teaching cultural competence and dispelling sexual stigma, but a dearth of information exists on the extent to which LGBT health topics are integrated into the nursing curriculum (Lim, Brown, & Kim, 2014).

Major difficulties in addressing LGBT health concerns include the shortage of faculty prepared to address these topics (Eliason, Dibble, & De Joseph, 2010), the perceived lack of time to integrate LGBT health topics, and religious bias by individual faculty members or academic institutions (Chinn, 2013). The inclusion of LGBT health topics in the nursing curriculum is limited and does not adequately address the complex health needs of LGBT persons across their lifespan (Dorsen, 2012; Eliason et al.; IOM, 2011; Sirota, 2013). The purpose of this study was to assess the knowledge, experience, and readiness of nursing faculty to teach LGBT health topics in baccalaureate (BSN) programs.

BACKGROUND

The impetus to integrate LGBT health into nursing education stems from growing evidence of unique health disparities affecting the LGBT population (Healthy People, 2011). Historic social and sexual stigmas are determinants of LGBT health that result in negative health outcomes when compared with their heterosexual counterparts (IOM, 2011). Related concepts that influence LGBT health patterns are the heterosexism and heteronormative constructs of society (Morrison & Dinkel, 2012; Rondahl, 2009). Societal stigma appears to elevate risk for mental health problems (Haas et al., 2011; King et al., 2008), sexually transmitted infections (STIs), including HIV/AIDS (Centers for Disease Control and Prevention [CDC], 2012; Grant et al., 2011), and substance abuse (Lee, Griffin, & Melvin, 2009; McCabe, West, Hughes, & Boyd, 2013).

Stigma also affects access to care. The National Center for Transgender Equality and National Gay and Lesbian Task Force found that discrimination by health care professionals is a major deterrent for accessing health care resources among transgender persons (Grant et al., 2011). The study also highlighted the lack of primary care providers knowledgeable about transgender health issues. Many studies have reported discrimination or poor quality care for sexual minorities (Healthy People, 2011).

GAPS IN THE NURSING CURRICULUM

Several older studies explored the attitudes of nursing students toward the LGBT population. Among the notable findings were lesbian phobia and misconception (Eliason & Randall, 1991), lower levels of comfort and negative attitudes toward sexual minorities (Eliason, 1998), correlation of a Christian belief with higher levels of homophobia (Schlub & Martsolf, 1999), lack of experience working with diverse groups and fear of contagion (Cornelius, 2006; Eliason & Raheim, 2000), inadequate knowledge about LGBT persons (Rondahl, 2009), and the desire to refrain from caring for homosexuals if given the option (Rondahl, Innala, & Carlsson, 2004).

Recent studies have reported lower levels of homophobia among nurse educators (Dinkel, Patzel, McGuire, Rolfs, & Purcell, 2007; Sirota, 2013). An integrative review of attitudes of nurses toward LGBT patients by Dorsen (2012) also uncovered mostly positive attitudes. However, improved attitudes do not automatically translate to greater knowledge or inclusion in the nursing curriculum, nor do all nurses have positive attitudes.

A survey of LGBT-related content in medical schools reported an average of five hours dedicated to teaching LGBT-related content in the entire curriculum (Obedin-Maliver et al., 2011). No similar data exist for the nursing curriculum. LGBT experts in nursing are unanimous in their observation that nursing education lacks curricular offerings on LGBT health (Brennan, Barnsteiner, Siantz, Cotter, & Everett, 2012; Chinn, 2013; Eliason et al., 2010; Rondahl, 2009).

THEORETICAL FRAMEWORK

Faculty behavioral determinants influencing the integration of LGBT health can be explained by the integrative model of a reasoned action approach. Based on the theory of planned behavior, the variables that account for variation in behavior in a given situation include “intention, attitude, perceived norms, self-efficacy or perceived behavioral control, behavioral beliefs, normative beliefs, and control beliefs” (Fishbein, 2008, p. 835). Faculty knowledge, their readiness, and their level of comfort to integrate

LGBT health into the curriculum all stem from behavioral intentions translated into what is actually taught in classroom and clinical settings.

An important consideration in applying the reasoned action approach is to clearly define the behavior of interest, reflecting the essential elements of action, target, context, and time (Fishbein, 2008). The following behavioral definitions are considered: action (teaching), target (LGBT health topics), context (baccalaureate nursing program), and time (variable). In the reasoned action approach, the intention to perform any behavior is the single best predictor of whether or not faculty will integrate LGBT health topics in their teaching (Fishbein).

METHOD

This study used a cross-sectional nonprobability survey design administered online through Qualtrics to a purposive sample of nursing leaders. Approval of the study was granted by the institutional review board (IRB) of a research university in the northeast region of the United States. Direct online solicitation emails were sent to all chief administrative leaders of schools of nursing (dean, chair, or department head) whose names and email addresses were publicly available on the website of the American Association of Colleges of Nursing ($N = 739$).

The invitation to participate explained the aims of the study, contained the survey link, and requested that the chief administrative leader forward the study link to all faculty teaching in the BSN program. Prospective participants were assured that data collection was anonymous, told that some people may feel uncomfortable addressing LGBT issues, and informed that they could withdraw from the study at any time. Participation in the survey was voluntary and no compensation or direct benefits were offered. Follow-up emails were sent to the chief administrative leaders two and four weeks after the initial invitation. The data collection took place in 2013 between September 8 and November 8.

Inclusion Criteria

All nursing faculty regardless of educational preparation, sex, ethnicity, and age were eligible to participate. The nursing programs represented were both online and traditional, and programs offered were generic, RN-to-BSN completion, and accelerated.

Questionnaire Design

A search of the academic literature (MEDLINE, CINAHL) for assessment tools for the inclusion of LGBT health in nursing education programs did not reveal any instruments that could answer the research questions of the current study. The literature review on LGBT health in nursing, medicine, social work, and other allied health professions, and the theoretical framework of reasoned action, informed the development of the 23 questions used in this study. The questionnaire was not meant to be exhaustive, but instead to represent salient features of faculty opinion about LGBT health knowledge, experience teaching LGBT health topics, and readiness to integrate these topics into the curriculum. Four content experts in LGBT health and nursing (faculty, researchers, and clinicians) reviewed the questionnaire for accuracy, relevance to current health priorities, and content validity.

Twelve of the 15 opinion questions were in Likert scale format with six possible responses, including an “I don’t know” option. Three were open-ended questions. Completing the questionnaire took less than 15 minutes. Using a content validity index (CVI), an item-level CVI (I-CVI) was calculated from ratings of the content experts to adjust for chance agreement (Polit, Beck, & Owen, 2007). An I-CVI of at

least .78 for at least three experts is considered to be good evidence of the validity of the content (Polit et al., p. 459). The final questionnaire had an I-CVI of .95.

Distribution of the Survey

Of the 739 chief administrative leaders invited to forward the survey link to their faculty, 15 requested a separate IRB approval from their respective schools. These schools were removed from the survey pool because of time constraints. One dean explained that the "topic of the survey is not congruent with our ethical and religious directives" and therefore did not participate. Another school declined but gave no reason for doing so. One school was currently conducting a survey similar to the present study and wished to be excluded. A total of 721 schools were included in this study.

Qualitative Data Analysis

This survey allowed participants to provide open-ended comments to three questions: 1) describe the strategies they perceived to be successful in promoting faculty readiness in integrating LGBT health topics into the curriculum (question 11), 2) teaching strategies used by the participant or the school to integrate LGBT topics into the curriculum (question 22), and 3) include any additional comments on the inclusion of LGBT topics in nursing programs (question 23). These three questions resulted in 823 qualitative comments.

To organize the qualitative data analysis process, the comments were uploaded into NVivo 10.0. The second author (MJ) used a conventional content analysis approach to analyze the qualitative data, meaning that themes were derived from the data and defined during data analysis (Hsieh & Shannon, 2005). While keeping the aim of the survey question in mind, MJ used an inductive process to create themes for questions 11 and 22. No new themes were identified for question 23; thus, the qualitative comments were assigned to relevant themes from questions 11 and 22. All the authors met throughout the qualitative data analysis process to discuss and refine themes. Disparities in opinions were discussed until everyone mutually agreed on final themes.

RESULTS

Description of Respondents

A total of 1,231 faculty members consented to take the survey and 18 declined. Because the total number of faculty who received the survey invitation is unknown, a response rate cannot be calculated. See Table 1 for descriptive information about the study participants.

Faculty Knowledge, Experience, and Readiness to Teach LGBT Health

Responding to the question on faculty awareness of LGBT health-related issues (n = 1,119), 37 percent indicated they were never or seldom aware and 25 percent were regularly aware; 36 percent reported they were often or frequently aware of LGBT health-related issues. In rating perceived knowledge of LGBT health care issues (n = 1,122), 43 percent reported limited or somewhat limited knowledge and 27 percent reported moderate knowledge; 29 percent reported they had full or adequate knowledge of LGBT health care issues. When asked how often they read about LGBT health-related articles in professional journals in the last two years, 70 percent indicated never or seldom and 14 percent

indicated regularly; 15 percent indicated they often or frequently read about these issues.

Participants rated how often they had taught LGBT health-related topics in the last two years from a list of 13 items; 23 percent to 63 percent indicated they never or seldom taught these topics (see Table 2). The most frequently taught topics were homophobia, HIV and STIs, LGBT youth issues, and violence and hate crimes. The least taught topics included obesity, inadequate access to health insurance, minority stress, and tobacco, alcohol, and drug use.

On rating their readiness to include LGBT health in nursing courses, 30 percent of respondents reported being only somewhat or not ready; however, 70 percent indicated being moderately or fully ready to teach LGBT topics. Similarly, 24.5 percent reported that they were somewhat or not comfortable teaching LGBT topics. The majority (80 percent) indicated that their department never or occasionally brought up LGBT health topics in faculty meetings (e.g., curriculum committee meetings).

The mean reported time devoted to classroom teaching of LGBT health topics for the entire nursing program was 2.12 hours (n = 605; SD = 2.1), with a range from 0 to 10 hours. More than 500 respondents did not answer this question; of those who did answer, 17 percent said there was no LGBT content in their curriculum, 53 percent reported 1 to 2 hours, 21 percent reported 3 to 5 hours, and 8 percent reported 6 to 10 hours. Data about clinical hours specific to LGBT health as well as prenursing courses devoted to LGBT health topics were not collected. Faculty awareness, knowledge, comfort, and readiness were significantly related to each other (all comparisons, $p < .001$).

Comparing Heterosexual Nurses with LGBT Nurses

Because our data may be biased due to the fairly large number of LGBT nurse faculty in the sample, we separated the data by sexual orientation. There were four transgender respondents, two of whom were lesbian, gay, or bisexual, and two who were heterosexual; therefore, their sex was treated as being either male or female. The sexual orientation data were recoded as lesbian, gay, bisexual, queer (LGBQ), or heterosexual, and all missing or ambiguous data were omitted.

The cleaned sample included 151 LGBT and 638 heterosexual respondents (331 missing data). This smaller sample of 789 respondents was used for the analyses that follow. No differences were seen in age, ethnicity, academic title (53 percent of LGBT and 54 percent of heterosexual faculty were tenure track, and 25 percent of LGBT and 23 percent of heterosexual faculty were tenured). Slightly more LGBT faculty reported having a doctoral degree (52 percent) than heterosexual faculty (45 percent), but this number was not significant.

KNOWLEDGE, COMFORT, AND READINESS LGBT nurse educators reported greater awareness of LGBT health issues (chi square = 324, $p < .000$); 40 percent of heterosexual educators, compared with 27 percent of LGBT educators, reported never or seldom being aware of these issues. LGBT faculty rated their professional knowledge of LGBT health issues higher than heterosexual nurses (chi square = 106.4, $p < .000$), and 47 percent of heterosexual nurses had limited knowledge compared with 21 percent of LGBT nurses. In the last two years, 12 percent of LGBT and 20 percent of heterosexual faculty had never read about LGBT issues in a professional journal. LGBT faculty reported a greater readiness to teach LGBT health issues (t = 22.1, $p < .000$) and a greater comfort level discussing LGBT health in their courses compared with their heterosexual counterparts (t = 10.55; p = .001).

FACULTY DEVELOPMENT ISSUES No significant differences were seen between LGBT and heterosexual nurse educators on perception about how often LGBT health-related issues were raised in faculty meetings, the importance of including LGBT health in nursing education, or the need for faculty development and training about LGBT health. LGBT and heterosexual faculty both agreed that it was necessary to include LGBT health in the curriculum. They also agreed on the average hours of LGBT health topics in their programs (LGBT faculty said 2.06 hours compared with 2.07 hours for

heterosexual faculty). This finding suggests that LGBT and heterosexual nurses are equally able to assess the level of LGBT health inclusion in the curriculum and generally agreed that it is an important topic. Surprisingly, they also were equally unlikely to have included LGBT health in the courses they taught (10 percent of LGBT faculty said that this content was nonexistent compared with 19 percent of heterosexual faculty who said the same).

TEACHING EXPERIENCE WITH LGBT ISSUES Significant differences were seen on 12 of the 13 items covering the last two years of experience teaching various LGBT health topics. The only item that did not differ had to do with LGBT youth issues, including suicide, bullying, and homelessness. LGBT faculty were unlikely to report teaching this content (see Table 3).

The 13 items were summed so that 13 would indicate no teaching of any of these topics, whereas higher scores would indicate a greater coverage of LGBT topics. Gay/bisexual male faculty members were the most likely to teach an LGBT topic ($M = 36.3$), followed by lesbian/bisexual female faculty ($M = 33.5$), heterosexual female faculty ($M = 28.8$), and heterosexual male faculty ($M = 23.7$), who were the least likely to do so. This is a significant difference ($F = 73.0$; $p < .000$), indicating a gender by sexual orientation interaction with no main effects. Heterosexual male faculty significantly differed from all three other groups.

Qualitative Results

In total, 573 qualitative comments were analyzed. The survey question about strategies to promote the integration of LGBT health into the curriculum included 200 comments, with four broad themes: curriculum, faculty, institution or policy, and stakeholders or community outreach. The qualitative comments were further categorized as being either a facilitator or barrier to the integration of LGBT health topics into the curriculum (see Table 4).

Respondents overwhelmingly commented on facilitators and barriers specific to the curriculum (54 percent). Facilitators included incorporating LGBT health with similar topics or promoting these topics as social justice or cultural competence; limited guidance on ways to integrate these topics and limited curriculum space were barriers. One respondent recommended “integrating LGBT health issues as part of the diverse spectrum, not as an entity of itself.” Many respondents made similar comments, for example: “I think it’s difficult to address each minority/special needs group individually.”

Respondents perceived that development sessions for faculty would facilitate the integration of LGBT health topics. Remarks included: “You must educate faculty about what LGBTI [I signifies intersex] stands for and get them comfortable with the idea” and “I attended a workshop on LGBT issues, and prior to that I was not aware of this population and the specific health care needs they have.” Faculty development sessions may help break down the barriers identified by respondents.

The remaining comments were specific to facilitators and barriers at the institutional or policy levels (19.5 percent) and stakeholder or community involvement (3.5 percent). Respondents remarked that incorporating LGBT topics on the NCLEX-RN examination or having institutional support could facilitate the integration of LGBT health topics into the curriculum. However, numerous respondents commented on strong institutional barriers, including social pressure by the institution, and noted that LGBT content was not required for accreditation. One person noted that her/his school “explicitly condones only sex inside of marriage and defines marriage as only between one man and one woman, [and] this makes it difficult to purposely include LGBT issues into curriculum.” Without the mandate from accrediting bodies to include teaching of LGBT topics, religious institutions can continue to block integrating these topics.

The question about teaching strategies used to integrate LGBT topics into nursing curricula received 373 comments, and nine themes emerged. Many comments (29.5 percent) revealed that

participants prefer to use traditional course work (adding lectures, class discussions, or readings within existing courses). Others (25.7 percent) remarked that incorporating LGBT health with similar topics is a useful strategy. Sample recommendations included teaching "LGBT topics in community health when discussing vulnerable populations" and teaching "LGBT health in pediatrics with adolescent growth and development, and again in adult medical/surgical with female and male reproductive systems." Other themes included using expert guest speakers (10.2 percent), LGBT-specific case studies (8.6 percent), LGBT community sites for clinical instruction (5.1 percent), class role play or simulation (5.1 percent), or seminars (1.0 percent) in order to integrate LGBT health into the curriculum. Some respondents (14.8 percent) indicated they were unsure of how to integrate LGBT topics or purposely chose not to teach these topics.

DISCUSSION

This study provided a glimpse into faculty knowledge, experience, and readiness to teach LGBT health in baccalaureate nursing programs. About 50 percent of respondents indicated knowledge limitations and lack of awareness with regard to LGBT health issues. This finding is probably connected to the limited discussion of LGBT health-related instructional topics in faculty meetings and curriculum committee meetings. Although there have been increasing numbers of publications on LGBT health topics in the last few years, the majority of respondents never or seldom read related articles in professional journals. This warrants further investigation. It is possible that selective reading of LGBT health publications may be a reflection of the perceived lack of time to keep up with topics traditionally seen as being part of a specialty.

The high importance that faculty placed on integrating LGBT health into the curriculum is matched by the expressed readiness and comfort discussing these issues by the majority of respondents. These findings mirror findings from a study by Sirota (2013); Sirota reported that 79 percent of nurse educators felt that teaching students about sexual minorities was very to extremely important. Nevertheless, approximately 75 percent of respondents in the present study indicated that LGBT health topics were non-existent or had limited inclusion in the courses they taught.

Based on a reasoned action approach framework, intentionality is the best predictor of behavior. It is unclear whether readiness and valuing have an impact on the intent of faculty to teach LGBT health topics. It can be surmised that willingness alone does not translate into the implementation of educational best practices for an LGBT health-inclusive curriculum. Factors such as perceived norms and beliefs may account for the disconnection between intention and actual behavior (Fishbein, 2008).

Policy impacts LGBT health curricular integration. For example, if the mission of a faith-based school follows specific religious doctrine that views homosexuality as deviant, LGBT health may not be addressed even if faculty are willing. Such systems barriers to implementation must be identified and addressed. In addition, it would be essential to identify LGBT health champions and allies among the faculty who will advocate for change. One respondent wrote, "The most powerful action for me was to become an ally to a[n] LGBT group." Educational policy change must be examined from a socioecologic perspective to gain a global understanding of LGBT health issues (IOM, 2011).

The Association of American Medical Colleges has issued clear recommendations for medical school curricula and medical educators to ensure that students master the knowledge, skills, and attitudes necessary to provide excellent, comprehensive care for LGBT patients (2014). No similar initiative has come from either the National League for Nursing (NLN) or the American Association of Colleges of Nursing (AACN). The NLN's Public Policy Agenda 2013-2014 states that the NLN supports

"government efforts, such as Title VII - Health Professions, to promote greater ethnic, cultural, and gender diversity and minority representation among nurses and nurse educators."

The majority of respondents valued faculty development programs on LGBT health to enhance readiness to integrate LGBT health into the curriculum. Presentation by expert clinicians, researchers, and policy advocates for LGBT issues through seminar workshops (e.g., "train the trainer") are needed to boost faculty readiness and comfort level in teaching LGBT health. Nursing education leaders can begin a collaborative partnership with local and national LGBT organizations, many of which provide training programs. The seamless integration of LGBT health topics in the classroom and the simulation and clinical settings must be competency-based and rooted in interprofessional collaboration. Suggestions for future studies include interventional research and outcomes analyses of faculty development programs geared toward enhancing faculty capacity in addressing LGBT health. Faculty development activities on cultural competency must be vibrant and sustainable.

Approximately one half of participants in the current study had been nursing faculty members for more than 10 years; the average age of participants was 50.6 years old. These findings, which reflect current national trends (AACN, 2012), are important because advancing age and longer years of experience as faculty are associated with more positive attitudes toward homosexuality (Sirota, 2013). They may explain the increased level of perceived readiness to teach LGBT health noted in the present study. This pattern could also be a reflection of a more tolerant atmosphere in academia or the result of social desirability bias (Dorsen, 2012). It is not clearly understood why these patterns do not translate into the curricular integration of LGBT health in nursing given the historical and continued emphasis in nursing education on teaching patient-centered care (American Academy of Nursing, 2012).

The median time of 2.12 hours devoted to classroom teaching provides a contemporary estimate of the coverage of LGBT health in baccalaureate programs. This particular survey question had significantly fewer responses compared with the other survey questions. It is possible that the majority of respondents did not know where LGBT health was taught in their programs. How much time should be devoted to this topic and how it should be integrated will continue to stir discussion.

Curriculum committees can best begin by conducting a cross-walk analysis of where gaps exist and what can be done about them. Competing agendas in education, limited resources, and value systems of individual schools will affect the sustained implementation of best practices to address LGBT health. Teaching strategies must go beyond enumerating health disparities. Information must include situated, contextualized scenarios that focus on cultural competence as well as those that are grounded in the values of social justice. Students must be supported in developing researchable questions pertaining to practice and policy in order to elevate their levels of inquiry.

A future research agenda would be to examine the quality of instruction with regard to LGBT health. Taught from a socioecologic model, students would gain a broader understanding of the influences resulting in health disparities unique among members of the LGBT population. To promote the application of cultural competency skills of students and allow the faculty to model these attributes, clinical placement in community-based LGBT health centers should be arranged when possible (Lim & Bernstein, 2011).

Competency requirements for nurse educators demand that faculty be responsible for designing or revising curricula to reflect contemporary societal and health care trends (NLN, 2005). Nurse educators can take advantage of web-based LGBT health resources when creating course syllabi (e.g., lavenderhealth.org, glma.org). Cultivating local expertise within faculty ranks, organizing in-house symposia, and collaborating with existing LGBT health programs (social work and medicine) within a university are potential avenues to be explored.

Limitations

This study had several potential limitations. Potential bias may have stemmed from the nonprobability sampling methods used. Although a relatively high number of respondents took part in the current study (N = 1,121), we were unable to estimate the response rate because the number of faculty who actually received the link to the survey was unknown. Power analysis was not conducted to estimate the minimum sample size required for this study.

Although the survey tool had a high I-CVI, it was not tested for reliability. Because respondents to the study were self-selected, we have reason to believe that faculty who already had an involvement and affinity with LGBT health topics were more likely to complete the questionnaire. This could have resulted in an overrepresentation of faculty who not only feel responsible for addressing LGBT health topics, but who also put this responsibility into practice.

It is possible that faculty who do not value the importance of LGBT health also did not complete the questionnaire. As an example, an email from a dean of a school explained that since the "survey is not congruent with our ethical and religious directives, the school will not participate in the study." It is likely that other nursing schools did not participate in the survey for similar reasons and that individual faculty with conservative religious beliefs may have been less likely to participate.

This study only included schools with BSN programs. The views of those teaching in associate degree, diploma, and graduate degree programs are not known, which limits the generalizability of the findings. Because data on geographic location of the participants were not collected, regional differences cannot be analyzed. Inaccurate recall and social desirability bias may have also influenced some of the responses and may limit generalizability of the findings.

CONCLUSION

This study examined the LGBT health teaching and learning needs of BSN faculty across the United States. The median reported time devoted to classroom teaching of LGBT health topics for the entire BSN program was 2.12 hours. A majority of respondents reported knowledge limitations and more than one third indicated a limited awareness of LGBT health issues. Although up to 63 percent indicated either never or seldom teaching LGBT health topics, 69 percent indicated LGBT health issues were important or very important in nursing, with the majority of respondents indicating some degree of readiness to include LGBT health in their teaching. The majority of respondents expressed a need for faculty development training in LGBT health.

To guide curricular programming, an informed understanding of educational gaps about LGBT health disparity must take place. Reviewing the curriculum to identify gaps in LGBT health topics was viewed by 75 percent of the respondents as the most essential strategy in aligning curricula with national LGBT health priorities. The four conceptual perspectives espoused by the IOM (2011) in guiding LGBT health research (minority stress model, life course, intersectionality, and social ecology) can be adopted as a framework for weaving LGBT health topics into specific nursing courses and for understanding the dynamics in advocating for curricular change.

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514

515 Table 1: Description of Respondents
516

Demographic	Findings
Age (*n* = 1,003)	Average age of respondents: 50.6 years (range, 24–77)
Race (*n* = 1,098)	White, non-Hispanic: 88% Black, African American: 4% Hispanic: 3% Asian: 2% Pacific Islander: 1% Other: 2%
Sex (*n* = 1,004)	Female: 90% Male: 8% Declined to answer: 2% Transgender: 4 respondents
Sexual Orientation (*n* = 1,097)	Heterosexual: 78% Gay: 4% Lesbian: 5% Bisexual: 2% Declined to Answer: 10%
Years of Teaching Experience (*n* = 1,115)	< 1 year: 6% 1–5 years: 27% 5–10 years: 24% > 10 years: 43%
Academic Degree (*n* = 1,119)	Baccalaureate: 2% Master's degree: 50% PhD: 31% DNP: 9% EdD: 6% DNS: 1%
Employment Status (*n* = 1,115)	Full-time: 86% Part-time: 7% Adjunct: 8%

517

518 Table 2: Frequency of LGBT Health-Related Topics Taught in the Last Two Years
519

Topic	Never (percent)	Seldom (percent)	Regularly (percent)	Often (percent)	Frequently (percent)
LGBT youth issues (e.g., suicide, bullying, homelessness)	41.3	25.0	18.7	6.6	7.8
Access to early detection programs among LGBT persons (e.g., HIV, cancer screening)	38.7	26.6	19.6	7.2	7.2
Exposure to HIV and other STIs among LGBT persons	29.9	26.7	25.4	8.3	9.3
Approaches to reduce HIV/STI risk	34.9	26.9	22.6	7.1	7.9
Obesity among LGBT persons	62.9	26.7	5.8	2.5	1.5
Access to health insurance	48.5	24.2	15.0	6.1	5.6
Need for referral to appropriate social services	42.3	25.9	18.4	6.4	6.4
Shortage of health providers knowledgeable and culturally competent in LGBT health	45.0	25.0	16.1	6.3	6.5
High rate of tobacco, alcohol and drug use among LGBT persons	49.9	23.9	14.3	5.4	5.8
Homophobia	34.1	24.1	22.5	8.9	10.1
LGBT minority stress	45.6	25.2	15.5	5.9	6.9
Violence and hate crimes against LGBT people	38.6	22.6	21.8	7.3	9.2
Need for LGBT health research	45.1	26.3	14.7	6.6	6.5

520 **Note.** LGBT = lesbian, gay, bisexual, transgender; STI = sexually transmitted infection
521

522 Table 3: Faculty Attitudes and Knowledge Data by Sex and Sexual Orientation
523

	Heterosexual Woman (percent)	Lesbian/Bisexual Woman (percent)	Heterosexual Man (percent)	Gay/Bisexual Man (percent)
LGBT health topics are unimportant	17	10	45	8
Feels uncomfortable addressing LGBT topics	28	14	14	13
Lack of awareness of LGBT health topics	40	30	34	23
Lack of knowledge of LGBT health	46	23	55	15

524 **Note.** LGBT = lesbian, gay, bisexual, transgender
525

526 Table 4: *Perceived Facilitators and Barriers to Integrating LGBT Health Topics in the Curriculum (n = 200)*
527

Themes	Responses (percent)	Facilitators and Barriers for Each Theme
Curriculum	54	**Facilitators:** Incorporate LGBT health with similar topics Promote LGBT topics as social justice, vulnerability issues, or cultural competence **Barriers:** Limited classroom time and space in curriculum Limited guidance on how to integrate LGBT topics
Faculty	23	**Facilitators:** Faculty development sessions on LGBT topics Demonstrate relevance and importance of LGBT topics to faculty **Barriers:** Opposes or uncomfortable teaching on LGBT topics Limited knowledge of LGBT topics
Institution or policy	19.5	**Facilitators:** Incorporate LGBT topics in NCLEX examination Institutional and school support **Barriers:** Social pressures of institution (religious institution) Not required for accreditation
Stakeholders or community outreach	3.5	**Facilitators:** Collaborate with LGBT community agencies when planning curriculum Include faculty and student LGBT organizations in curriculum discussions

528 **Note.** LGBT = lesbian, gay, bisexual, transgender